



**GROUP INSURANCE COMMISSION**  
**Authorization for Release of Health Information**

I, \_\_\_\_\_ at (address) \_\_\_\_\_,  
give permission to (name of covered entity) \_\_\_\_\_ to release  
to a representative of the Group Insurance Commission the following information  
about me for the following reasons:

**Information:**

**To be used for\*:**

\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

\*If you do not wish to state a purpose, please state, "At the request of the individual."

**OR**

I, \_\_\_\_\_ at (address) \_\_\_\_\_,  
give permission to a representative of the Group Insurance Commission to release  
to \_\_\_\_\_ the following information about me for the  
following reasons:

**Information:**

**To be used for\*:**

\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

\*If you do not wish to state a purpose, please state, "At the request of the individual."

- (1) Right to revoke: I understand that I have the right to revoke this authorization at any time by notifying the Group Insurance Commission in writing at P.O. Box 8747, Boston, MA 02114. I understand that the revocation is only effective after the Group Insurance Commission receives and logs it. I understand that the revocation does not apply to any use or disclosure made prior to revoking my authorization.

- (2) I understand that the Group Insurance Commission might make use or disclosure of information that I authorized prior to my revocation of the authorization.
- (3) I understand that I do not have to agree to release this information in order to be eligible for continued benefits that I am entitled to, as long as my eligibility for those benefits can be determined without releasing that information.
- (4) I understand that after this information is disclosed, federal law may not protect it and the recipient may re-disclose it.
- (5) I understand that I am entitled to receive a copy of this authorization.
- (6) I understand that once the information has been given out for the stated purpose, my permission for the release ends.

**Signature of Enrollee/Personal Representative:** \_\_\_\_\_

**Date:** \_\_\_\_\_

If a Personal Representative for an enrollee executes this form, indicate below the nature of the authority to sign this form on the enrollee's behalf:

\_\_\_\_\_

Witness: \_\_\_\_\_ Date: \_\_\_\_\_

**GROUP INSURANCE COMMISSION**

**AUTHORIZATION REVOCATION**

Name: \_\_\_\_\_

Address: \_\_\_\_\_

SS#: \_\_\_\_\_

DOB: \_\_\_\_\_

I hereby revoke the Authorization for Release of Information that was signed by me or my Personal Representative on \_\_\_\_\_ (date), for \_\_\_\_\_ and \_\_\_\_\_ to share protected health information.

I understand that this revocation will not apply to information that has already been released. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

\_\_\_\_\_  
Signature of individual or Personal Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print name

Indicate relationship of person signing this form to the individual

☐ Person signing is the individual

☐ Person signing is the Personal Representative authorized to make medical decisions for the individual. Type of authority (e.g., court appointed, custodial parent) \_\_\_\_\_

**A COPY OF THIS FORM SHOULD BE GIVEN TO THE GIC AND THE OTHER PERSON/FACILITY/AGENCY.**